Massachusetts Department of Mental Retardation
Gastrostomy / Jejunostomy Registration Form

Date: _____
Region:_____ Area/Facility:_____ Class Org:_____
Provider Agency:_____
Site Address:_____DPH MAP Reg. #_____
Name of Individual with G/J Tube:_____
Date of Birth:_____ S.S. #:_____

Type of Tube: Gastrostomy____
Jejunostomy____

Date of Placement of G/J Tube (approximate if necessary):_____
Reason for Placement of G/J Tube:
_____ Dysphagia
_____ Chronic Aspiration
_____ Nutrition Concerns
_____ Hydration Concerns
_____ Other (Please Specify)_____
_____ Unknown

Does this person:
_____ receive feedings via their G/J tube?
_____ receive hydration via their G/J tube?
_____ receive medications via G/J tube?
_____ have medications administered via G/J tube by licensed person?
_____ have medications administered via G/J tube by MAP certified staff?

I have evaluated this individual and have determined that it is appropriate at this time for MAP certified, non-licensed staff to be trained to administer medications via their:

(Initial one)
____ gastrostomy tube
____ jejunostomy tube

_____	_____	_____
Name of RN, NP or Physician	**Signature of RN, NP or Physician**	**Date**